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FAMILY PHYSICIANS  
OF CANADA



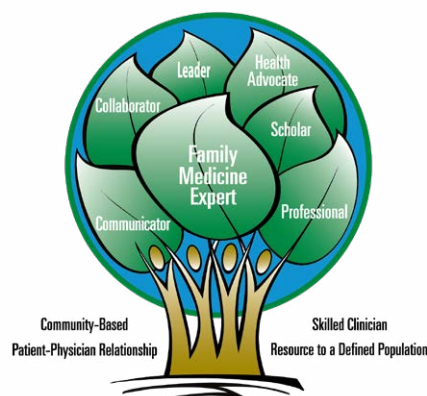
LE COLLÈGE DES  
MÉDECINS DE FAMILLE  
DU CANADA



# CanMEDS–Family Medicine

## Indigenous Health Case Study Compendium

Second Edition



## CanMEDS-Family Medicine

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Image adapted from the CanMEDS Physician Competency Diagram with permission from the Royal College of Physicians and Surgeons of Canada.

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# Introduction

For First Nations, Inuit, and Métis peoples, storytelling honours oral tradition while also being an important method of knowledge sharing. Storytelling transmits experiences across generations in a memorable or metaphoric way. This innovative method of knowledge translation has gained recent recognition in the realm of “narrative medicine.”<sup>1</sup> This case study compendium to the 2020 CanMEDS Family Medicine (CanMEDS-FM) Indigenous Health Supplement<sup>2</sup> has been created to further enhance understanding and promote high-quality care that supports the right of First Nations, Inuit, and Métis peoples to attain the highest quality of health care.<sup>3</sup>

Storytelling, also referred to as case studies and/or narratives, is a powerful way to support health professionals to learn from and reflect on personal or systemic biases that may shape their practice. The case studies in this guide provide information about encounters in the health care system from the perspective of First Nations, Inuit, and Métis peoples. The details provided allow for readers to engage in self-reflection and dialogue around the presented narratives.

Readers will note that a psycho-social assessment is offered with each case. First Nations, Inuit, and Métis peoples share a holistic perspective regarding the health and well-being of themselves and their families. Among Indigenous peoples, when considering health, aspects of physical, mental, emotional, and spiritual wellness are considered. Family medicine practitioners consider the psycho-social context when working with patients across the life span, and in this way they show alignment with Indigenous perspectives on health and wellness.

## Learning Outcome

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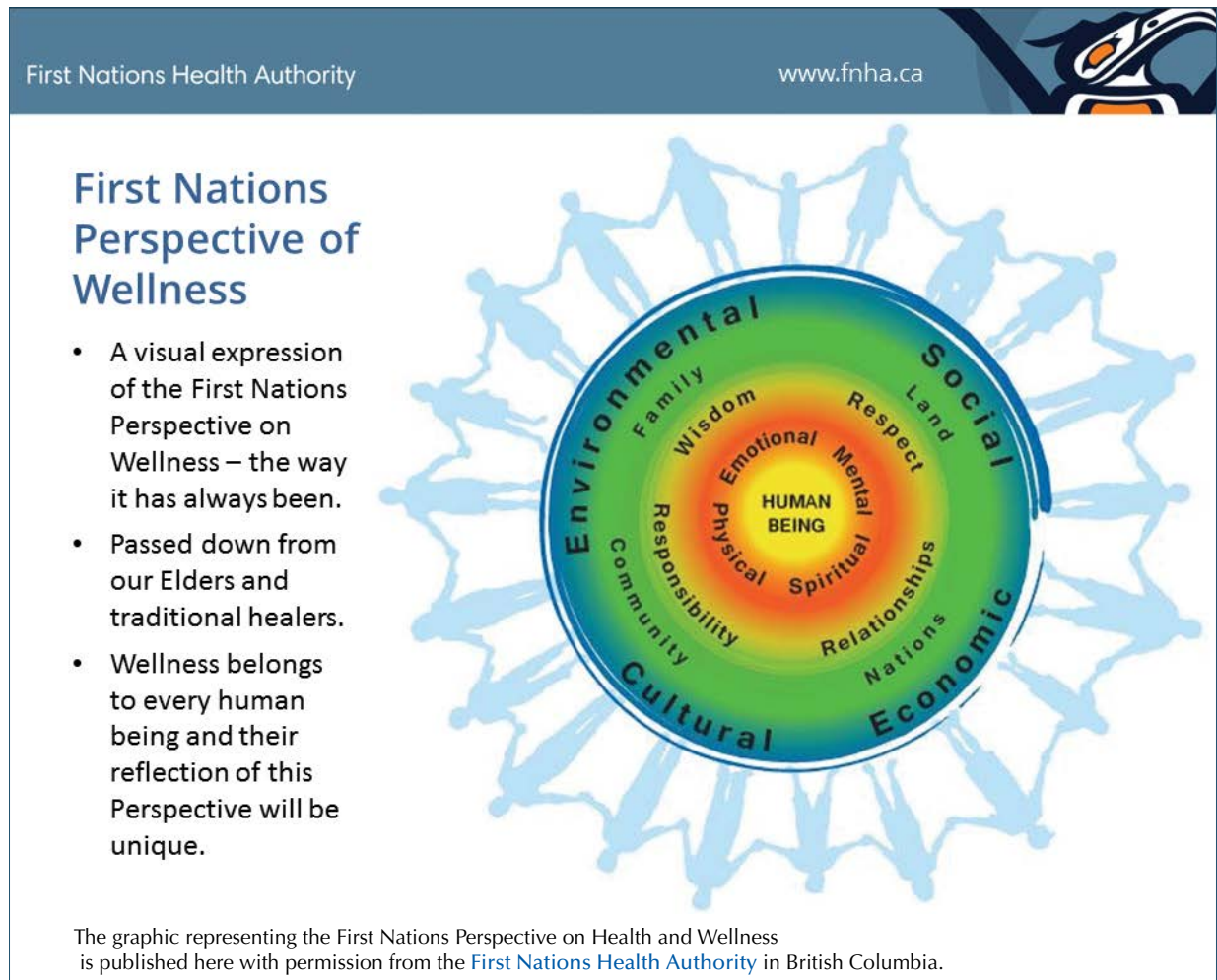
**The information in this compendium is designed to demonstrate and acknowledge the culturally unsafe care that exists throughout the health care system and provide learning points to broaden the foundation of knowledge for family physicians, medical trainees, and educators to better engage in care that authentically respects Indigenous peoples’ right to health justice that considers their cultural, historical, political, and social contexts.**

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While not all Indigenous peoples use the medicine wheel, there are many similarities to be found across all groups in terms of looking at the whole person (body, mind, spirit, and emotion) when assessing well-being. Using this approach with Indigenous patients can demonstrate a deeper understanding of the Indigenous perspective of health and wellness. For a visual representation of the holistic model used extensively in British Columbia through the First Nations Health Authority, see **Figure 1**.



**Figure 1.** First Nations Perspective on Health and Wellness



For each case in this compendium, insights about the Indigenous patient and/or the Indigenous patient’s family are included to support understanding the experiences of seeking and receiving care in a health care system.

Learning points are offered to support discussion and self-reflection regarding the details of the case. While not an exhaustive list of learning outcomes for each case, many of the points reflect the key competencies found in the CanMEDS-FM Indigenous Health Supplement.

In addition to the CanMEDS-FM Indigenous Health Supplement, the Royal College of Physicians and Surgeons of Canada (Royal College) released information to support a deeper understanding of the Indigenous perspective on health. The *Indigenous Health Values and Principles Statement*<sup>4</sup> nests each of the seven CanMEDS roles with Indigenous values and principles to deepen awareness. A table (see Appendix A), created for this case study compendium, links the CanMEDS roles with the Royal College’s values and principles in addition to the key competencies listed for each of the seven roles, as found in the CanMEDS-FM Indigenous Health Supplement. Readers can use the table as a quick reference guide to support enhanced learning of an Indigenous health perspective for each role.

# Facilitator's Guide for the Case Study Compendium

## Call to Action

As a guest living, working, and playing on traditional territories of First Nations, Inuit, and Métis peoples, and family medicine practitioner, you are being trusted to work in a culturally safe and anti-racist way. As family physicians, we are called to work with Indigenous peoples using an approach that is trauma informed and healing centred. Trauma-informed care acknowledges how colonization continues to impact the health and lived experiences of Indigenous peoples and is an approach that encourages the support and treatment of the whole person instead of focusing on individual symptoms and specific behaviours. Health inequities are disparities between population groups that are broadly systemic, avoidable, and unjust. Family physicians can address the ongoing traumas of colonization while emphasizing the strengths of Indigenous peoples and communities.

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**“Addressing inequity involves engaging with broad social dynamics, important for application within clinical practice, that ultimately requires multisectoral advocacy. Addressing inequity also compels family physicians to look at their clinical approach—at the nature and quality of health care they provide to ensure they do not perpetuate structural and systemic violence.”**

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*CanMEDS–Family Medicine Indigenous Health Supplement<sup>1</sup>*

Ongoing calls for change to address discrimination for equity-seeking populations, and in particular to address anti-Indigenous racism in Canada's health care system makes clear that we are still in the early stages of this work. Evidence based papers such as the *In Plain Sight* report and *First Peoples, Second Class Treatment* show that “racism against Indigenous peoples in the health care system is so pervasive that people strategize around anticipated racism” before seeking care or, “in some cases, avoid care altogether”. **We think we're doing a good job, but we're not yet seeing the changes that are needed to address health inequities.**

As family medicine learners and practitioners, you are often asked to reflect and give or receive feedback on interactions relating to culturally respectful care. This can be an act of mutual learning between yourself, other physicians, and other learners you work with. **If we want systemic change, we need to actively seek out more accountability from ourselves, our colleagues, and from the system.**

# Background

Recognizing the need for innovative ways to support the ongoing learning journey regarding cultural agility in family medicine, the Indigenous Health Committee (IHC) of the CFPC produced the *CanMEDS–Family Medicine Indigenous Health Supplement* (Supplement) in 2020.<sup>1</sup> In 2023 the Committee released a compendium of narratives (cases) to support further awareness and understanding of the competencies outlined in the supplement. Please read the Supplement and become familiar with the content. This is prerequisite learning for this case study compendium.

When teaching a course, instructors make a range of judgements: what course material to teach, whether or not to link course material to social practices, and how to position students in relation to the world around them. Teaching how to provide care to equity-seeking populations with cultural safety and humility can be well-supported by using scenarios or cases, as there are many nuances to this work. This facilitator’s guide can enable conscious planning that can lead to a successful learning experience for participants and facilitators alike. The following considerations may be helpful reminders before designing an educational experience:

- Learning in a group setting is strongly recommended. We encourage participants to initiate conversations about the competencies from the Supplement with their preceptors and/or colleagues.
- Deepening our understanding of and practising culturally respectful care requires that we approach educational and experiential opportunities with an open mind and, perhaps even more importantly, an open heart
- This learning can be difficult. Practise self-care before and after learning. As family medicine practitioners, we need to reflect on what we’re doing and how we’re practising in an open and truthful way.
- Be mindful of involving Indigenous learners who may be familiar with some of the themes and experiences discussed in the cases

## Reminders

- Encourage each learner to stay with the content, even if the process feels uncomfortable
- Don’t quit or give up if mistakes are made
- Self-reflection is a critical aspect to this learning
- Continue to reflect, retain humility, and keep learning
- Reconciliation is life-long process—**it is not a one-and-done type of learning**
- Cultural safety education is supportive education for practitioners. The absence of cultural safety can result in harm or even death for people we provide care to.
- Anti-racism education is essential learning to address and eradicate the racism and discrimination in the health care system today

# Overview

**Cumulative time:** One to 1.5 hours per case

**Prerequisite reading:** *CanMEDS–Family Medicine Indigenous Health Supplement*, the Indigenous Health Committee, and *Reflexive Questions for Educators and Facilitators*.<sup>4</sup>

**Note:** This learning includes progressive approaches to reflect that learning is ongoing for both participants and educators. Depending on the participants' level of experience and engagement regarding Indigenous health and well-being, facilitators can tailor the lesson plan accordingly by following prompts for baseline, developing, or extending learning approaches.

As educators supporting medical education, reflexivity, critical, and self-reflection are important skills that can support the design and delivery of curriculum. "Value-laden decision-making moments exist throughout the education process, from syllabus design and guest lecturer selection to content, delivery, and pedagogical choices. Reflexive questions can help unearth some of the implicit values and assumptions embedded in our choices." Recommended pre-reading for facilitators of this session include a reflexive questions guide for educators and facilitators to help enhance facilitation practice in this area.

## Learning objectives

- Demonstrate and acknowledge the culturally unsafe care that exists throughout the health care system
- Provide learning points to broaden the foundation of knowledge for family physicians, medical trainees, and educators
- Support better engagement in care that authentically respects Indigenous peoples' right to health justice and that considers their cultural, historical, political, and social contexts

**Materials:** Copy, or copies, of the *CanMEDS–Family Medicine Indigenous Health Case Study Compendium* (Compendium).<sup>5</sup> If you do not have printed copies, have the electronic copy open and projected, using a screen and projector.

**Physical space set-up:** Chairs in a circle, facing inward (with paper copies of the Compendium available). Chairs in a horseshoe shape, facing the screen (if using electronic version of Compendium). This learning can take place anywhere: a kitchen table, a community hall, etc.

**Virtual space set-up:** Open plenary to begin, potential for breakout rooms for discussion.

### Facilitators:

Baseline: Lead should be familiar with the Supplement, and well-versed in anti-racism principles and approaches.

Developing: Lead has experience developing and/or delivering curriculum that works toward the integration of Indigenous health into medical education curriculum.

Extending: Co-facilitation model with Indigenous and non-Indigenous faculty. Familiarity with integration of Indigenous health to medical education curriculum.



## CFPC Case Study Compendium – Lesson Plan Template

Time (Minutes)	Detail
15	<p>Opening and welcome</p> <p>Baseline: Welcoming people to the session, acknowledge the land on which the session is taking place.</p> <p>Developing: Offer a grounding exercise, if that is available to you as a facilitator. Connecting to self, connecting to the land. Offer something you're grateful for regarding the land on which the learning is happening.</p> <p>Extending: Set some group norms and/or shared values throughout the learning experience.</p> <p>Examples of shared values may include:</p> <ul style="list-style-type: none"> <li>• Committing to being respectful</li> <li>• Being open to new concepts</li> <li>• Connecting this work to the idea that we are working on behalf of Indigenous peoples and, in that way of thinking, for seven generations moving forward from where we are today</li> </ul> <p>This work requires us to be connected with yourself and others. To pay attention to things we may not normally pay attention to. This is <b>heart</b> work, not so much head work. This work is not easy. We need to be more focused and more self-aware when we are learning together about health equity.</p> <p>Extending: <b>Offer space for an Indigenous faculty, community member, or Elder to open the session in a good way</b>, if they feel welcome and safe to do so.</p>
15–20; longer if you have more people in the room	<p>Introductions</p> <p>Plan on approximately two minutes per person. Have participants introduce themselves, their backgrounds/ancestry (if known), a bit about who they are as people, and less focus on their role. Taking the time for each participant to introduce themselves helps people to see themselves as a team. No one works alone in health care. It is important to foster a sense of teamwork.</p>
5	<p>Provide an introduction to the Compendium as a resource.</p> <p>Show the front cover of the resource on the screen or pass around printed copies.</p> <p>Emphasize that the Compendium is meant to deepen learning from the Supplement and its associated competencies for providing culturally respectful care to Indigenous peoples.</p> <p>Familiarity with the Supplement is a pre-requisite for this learning for participants.</p>
2	<p>Choose the narrative that you will be offering.</p> <p>Have one of the participants read the Definition section for the role highlighted in the case (narrative) out loud.</p> <ul style="list-style-type: none"> <li>• Emphasize that while each case highlights one of the seven CanMEDS roles it is difficult to assign just one role to each case as many are overlapping and complimentary</li> <li>• Encourage participants to think about the role that is highlighted but also to consider which of the other seven roles are present in, or absent from, the narrative</li> </ul>
5	<p>Reflective questions regarding the Definition:</p> <ul style="list-style-type: none"> <li>• What sticks out to you from the Definition you've just read? Why?</li> <li>• Was there anything offered in the Definition that feels 'new' to you?</li> </ul>
2	<p>Ask someone to read the Narrative aloud, along with the History section of the case.</p>

Time (Minutes)	Detail
5	<p>Reflective questions:</p> <ul style="list-style-type: none"> <li>• Baseline: What happened in the narrative?</li> <li>• Developing: How was the main role reflected or not reflected so far in this narrative?</li> <li>• Extending: What are some of the strengths demonstrated by the patient or their family?</li> </ul>
8	<p>Have each participant read the Assessment section to themselves and reflect:</p> <ul style="list-style-type: none"> <li>• Developing: Why do you think the Assessment is laid out with considerations in four different areas: physical, mental, spiritual, emotional?</li> <li>• Extending: The importance of spirituality. We can think of this as what the person may be connected to, what gives them hope. It is not always affiliated with a religion. Reflect on whether this feels different from your own experience of spirituality.</li> </ul>
8	<p>Ask someone to read the Narrative update.</p> <p>Reflective questions:</p> <ul style="list-style-type: none"> <li>• What other CanMEDS roles do you feel apply to this case? Why?</li> <li>• What do you think needs to happen now?</li> </ul>
2	<p>Ask a different participant to read the section Indigenous perspectives – experiences of seeking and receiving care.</p>
8	<p>Reflections:</p> <ul style="list-style-type: none"> <li>• Baseline: What stands out to you in hearing about the Indigenous perspectives?</li> <li>• Developing: Can you identify barriers to care for the patient?</li> <li>• Extending: How do social determinants of health play a role in this narrative?</li> </ul>
10	<p>Have each participant read through the Learning Points section. Using the table at the end of this document, ask each participant to reflect on each of the CanMEDS Roles and how they were present or absent in the case.</p>
5	<p><b>Final discussion:</b></p> <ul style="list-style-type: none"> <li>• How can you, as a family medicine practitioner, think about activating these roles in your practice?</li> <li>• How might the roles present in this case be more mindfully employed when working with Indigenous patients?</li> </ul>
10	<p>Extending: Elder – closing reflections</p>
<b>Addendum</b>	<p>Create a space throughout the session to capture any lingering questions that may arise about the approaches discussed or the case itself. Some facilitators call this a 'parking lot'. If, by the end of the case study, questions captured have not yet been answered use the following prompts to support the learners to take next steps to find the information they are seeking.</p> <p>Consider how answers could be sought out using the following self-reflection questions, putting the onus on the learner, rather than leaning on First Nations, Inuit, or Métis colleagues. The following questions are based on the work of Dr. Daniele Behn Smith and Dr. Kate Jongbloed for their "Unlearning and Undoing Systemic White Supremacy" work with the British Columbia Office of the Provincial Health Officer.<sup>7</sup> The reflection questions were developed as part of a two-year initiative for their work. Learn more by visiting <a href="https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/unlearning-undoing-project">https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/unlearning-undoing-project</a>.</p> <ul style="list-style-type: none"> <li>• What research and engagement have I and my team done to learn about the original peoples on whose lands our work is situated? What do we know about how settler colonial harms the First peoples of these lands have experienced and continue to experience?</li> <li>• What research and engagement have I and my team done to understand our obligations towards reconciliation that are specific to our area of work? (i.e., the particular Calls to Action from the Truth and Reconciliation Commission of Canada's Final Report)</li> <li>• How are we taking steps to advance reconciliation and how are we tracking our accountability in meeting the obligations specific to our work?</li> <li>• How might an exploration of the responses to the questions outlined above influence my roles as a family physician?</li> </ul>

# CanMEDS Case Study Compendium Role Reflections

To be completed by participants after discussing one of the case studies.

- Can you identify where systemic racism is at play in this narrative?
- Can you identify some of the patient’s strengths?

CanMEDS Role	How was this role demonstrated or not demonstrated in this narrative?
<b>Leader</b>	
<b>Collaborator</b>	
<b>Professional</b>	
<b>Health Advocate</b>	
<b>Scholar</b>	
<b>Communicator</b>	
<b>Family Medicine Expert</b>	

# Endnotes

1. Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement*. Mississauga, ON: The College of Family Physicians of Canada; 2020. Accessed August 21, 2024. <https://www.cfpc.ca/CFPC/media/PDF/CanMEDS-IndigenousHS-ENG-web.pdf>
2. Government of British Columbia. *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*. Victoria, B.C.: Government of British Columbia; 2020. Accessed August 21, 2024. <https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf>
3. Allan B, Smylie J. *First Peoples, Second Class Treatment: The role of racism in the health and well-being of Indigenous peoples in Canada*. Toronto, ON: The Wellesley Institute; 2015. Accessed August 21, 2024. <https://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Full-Report-FPSC-Updated.pdf>
4. Centre for Advancing Collaborative Healthcare & Education *Reflexive Questions for Educators & Facilitators*. Toronto, ON: Centre for Advancing Collaborative Healthcare & Education; 2024. Accessed August 21, 2024. <https://ipe.utoronto.ca/sites/default/files/assets/files/cache-reflexive-questions-educators.pdf>
5. Indigenous Health Committee. *CanMEDS–Family Medicine: Indigenous Health Case Study Compendium*. Mississauga, ON: College of Family Physicians of Canada; 2023. Accessed August 21, 2024. <https://www.cfpc.ca/CFPC/media/Resources/Indigenous-Health/CanMEDS-Indigenous-Health-2023-EN.pdf>
6. Loppie C, Wien F. *Understanding Indigenous health inequities through a social determinants model*. Prince George, BC: National Collaborating Centre for Indigenous Health; 2022. Accessed August 21, 2024. [https://www.nccih.ca/495/Understanding\\_Indigenous\\_Health\\_Inequalities\\_through\\_a\\_Social\\_Determinants\\_Model.nccih?id=10373](https://www.nccih.ca/495/Understanding_Indigenous_Health_Inequalities_through_a_Social_Determinants_Model.nccih?id=10373)
7. Government of British Columbia. Introduction to Unlearning & Undoing White Supremacy and Racism in the Office of the Provincial Health Officer. Accessed September 1, 2024. <https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/unlearning-undoing-project>



## **Sensitive Content Warning**

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The content in the narratives presented in this document may create unpleasant feelings and memories of negative experiences. Truth-telling is an important part of reconciliation. Feelings of discomfort may be experienced by First Nations, Inuit, or Métis peoples reading these stories as they may reflect their own or their family's experiences of harm in the health care system. Non-Indigenous readers may also feel unease when reading these stories. We ask that all readers bear witness to the experiences of systemic racism that are often hidden from view. These stories are meant to acknowledge that culturally unsafe care exists in the health care system and are presented here with the intention of exposing that racism and to provide learning points to help address it. If you require support, please reach out to a trusted friend, mentor, or counsellor.

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# Family Medicine Expert

## Additional tags:

Collaborator, Communicator,  
Leader, Advocate, Scholar

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## Definition

As family physicians, we are generalists with a high level of knowledge and skills that enable us to provide high-quality, responsive, community-based care to Indigenous peoples living in Canada, regardless of where they live. We commit to delivering respectful, comprehensive, and responsible care that is informed by the context of our Indigenous patients. As practitioners, we are called on to commit to knowing and learning about such toxic traumas and history as residential school experiences; murdered and missing Indigenous women and girls (MMIWG); the 2SLGBTQ+ discrimination; the effects of environmental and industrial events; and current situations that impact individual and community health (e.g., a suicide crisis or multiple drowning tragedy). Both Indigenous and non-Indigenous people are called on to protect the land. Our collective physical, mental, and spiritual health depends on it.



As family medicine experts, we practise with clinical courage,<sup>5</sup> providing compassionate care, engaging with patients and their communities, acting in all the roles described in the CanMEDS-FM Indigenous Health Supplement 2020.<sup>2</sup> We will work with Indigenous peoples, whether we practise in urban, rural, or remote settings. First Nations, Inuit, and Métis people live in both homogenous and diverse populations that span all these settings.

We are called to view our medical careers as a journey, embracing lifelong learning, and expanding and focusing our knowledge and skills in response to the needs of Indigenous people and their communities. Our practices should be patient-centred, collaborative, respectful of all, and extending across the life cycle.

## Narrative

An Inuvialuit male, Tommy, has come in to see you with complaints of headaches and frequent upset stomach. Tommy is 12 years old and lives with his single mom and four siblings, in a house with his grandparents and two other relatives.

## History

Tommy is not doing well in school. He says he doesn't like school as he finds it hard. He talks about getting headaches after feeling pressured. He often feels worried. Tommy talks about the difficulties of living in a crowded house and his family's financial struggles.

Tommy is hanging around with other preteens who negatively influence him. He has started smoking. He eats junk food and eats only one meal per day. Tommy claims to have started drinking on weekends.

## Psycho-social assessment

**Physical:** Vital signs and physical assessment, including neurological exam, are normal.

**Mental:** Low marks, in danger of failing school. Not motivated. A teacher at school belittles his efforts.

**Emotional:** Tommy is worried about his mom and all she must do to care for the household. He feels down sometimes, is lonely, and does not have many close friends. He lost two friends to suicide in the last two years.

**Spiritual:** Likes to go out hunting and fishing with his grandfather.

## Narrative update

You see Tommy a few more times. Tommy opens up and tells you he is sad sometimes, is often lonely, and doesn't always get along with his mom and siblings.

You encourage him to spend time with his mom and talk about what bothers him. You support him to stop smoking and drinking. He has found some new friends and more positive influences at the youth centre.

On your day off, you go fishing with an Inuvialuit family and learn more about the culture and traditions.

## Indigenous perspectives – experiences of seeking and receiving care

Tommy goes to the first appointment because his mom is concerned about him. He does not trust doctors. So many doctors that work in the health centre are only here for a short time, and do not connect with the community members at all. Like the teacher who is here from 'down south,' Tommy suspects the doctor doesn't have a clue of what it's like to live in the community and the problems that he and his family face. The doctor will probably work here until his time is up and then return south.

Tommy thinks this doctor seems different. He did not seem to be in a rush and took time to ask about school, about Tommy's family and friends. He asked if Tommy would like to see him again to talk. No

one had ever directly offered Tommy a choice to participate in decisions about his health. Tommy is curious about seeing this doctor again and agrees to go back.

At the next appointment, the doctor asked about what makes Tommy happy and was interested when Tommy talked about being on the land with his grandpa. This doctor said he would like to come out fishing some day. When Tommy shared about losing his friends who had committed suicide, the doctor said he was sorry about his friends. The doctor was aware of the cultural centre youth group and asked if Tommy had ever gone there. Tommy had not, but after the doctor shared some information about the group, Tommy agrees to try it.

Tommy sees the doctor during a community fishing day. The doctor stayed after the fishing to share a meal with the community and brought his family with him. Tommy's family was talking about the doctor at home the next day because they were happy to see the doctor brought his family to the feast. It's not very often that health professionals from down south participate in community events.

At the next appointment, the doctor says it was good to see Tommy at the event and noted how happy he seemed when he was fishing with his grandpa. It made Tommy feel special to know that the doctor saw the time spent on the land with his grandpa, as this is important to him. When the doctor asked about risky behaviours that Tommy's mom said he was engaged in, Tommy was able to open up to the doctor and share why he is smoking and using alcohol. Tommy feels receptive to keeping connected to the youth program at the cultural centre.

## Learning points

- Tommy is an Inuvialut person. It is important to learn about the different First Nations, Inuit, and Métis nations and subgroups, sometimes based on geographical or traditional territories' contexts.
- Establishing a relationship with Indigenous patients and their families, including in emergent situations, contributes to identifying and setting priorities for assessment and management
  - With Tommy, this will likely require more than one visit. It is important to make him feel safe so he will share more about his worries.
  - Once trust and a good therapeutic relationship are established, it may be easier to explore Tommy's risky behaviour (alcohol, smoking)
- As we know, crowded housing can impact health and social well-being. Housing is a social determinant of health.
- With all patients, and in particular with Indigenous people, family supports are important. We endeavour to engage family members in support of the individual's wellness.
  - For Tommy, recruit and involve his mom and grandparents, as you have discovered through conversations that Tommy is close with both



- As Collaborator is one of the CanMEDS roles, we are called to work with the patient, the family, and any other relevant team members when working in Indigenous communities. Family physicians bring to each encounter all their knowledge, skills, and empathy.
  - Youth centre staff can link Tommy to activities and resources
  - A youth counsellor can help Tommy vent about his family situation and help strengthen his relationship with his mom
  - Consider collaboration with the school nurse. Perhaps she can connect Tommy to a tutor or find a mentor (older student perhaps) to encourage school attendance.
  - Build familiarity with the community to foster relationships, understanding, and trust
- Listen to the patient. Seek out the patients' ideas about their health and whether they practise or wish to use traditional Indigenous health practices. Such ideas are received openly and without judgement.
  - Encourage Tommy to consider positive ways to cope with stress—walking, sports, going out to the bush with grandparents
  - Find out what resources are available through the regional, provincial, or territorial governments; for example, the Inuvialuit Regional Corporation and SportNorth for Tommy to connect with
- We are encouraged to participate in important events such as funerals, and community activities such as sporting events, harvests, or feasts
  - Don't hesitate to show interest or ask if you would be welcome to attend events, being mindful that some events are not open to non-community members

# Communicator

## Additional tags:

Leader, Advocate, Professional, Collaborator

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## Definition

Communication with Indigenous patients entails engaging in the same interview tasks (such as relationship building, information gathering, explaining, and planning) as with non-Indigenous patients. However, effective communication with Indigenous patients also involves responsive adaptation of interview tasks to consider an additional range of cultural (patient and physician) and societal (arising from colonization) contexts.

## Narrative

Matthew is a 72-year-old Cree man who comes to the clinic for routine diabetes follow-up. Matthew is a retired iron worker and often goes to a cabin on his trapline and fishes or hunts for his family. He is a residential school survivor and a language speaker. Matthew's blood sugar (HbA1c) has improved significantly over the past year. When he comes into the clinic for his appointment you overhear the clinic manager mutter, "at least he showed up this time."

## History

Matthew was diagnosed with diabetes in the last 10 years but likely had diabetes for years beforehand, as he received sporadic primary care most of his life. He has hypertension, renal insufficiency, and osteoarthritis in both knees. He had tuberculosis as a child in residential school. When his wife passed away two years ago, he moved in with his son and family. He is very involved in his community and enjoys time on the land. He drinks a beer or two when watching hockey on television, walks every day, and eats traditional food often.

## Assessment

**Physical:** Blood pressure (BP) 140/95, pulse 60 beats per minute (BPM), physical exam unremarkable, hemoglobin A<sub>1c</sub> (HbA<sub>1c</sub>) 7.9 (down from 10.3 last year), lipids at target good (on statin), recent creatinine 160 estimated glomerular filtration rate (eGFR) 40. Takes his medications regularly.

**Mental:** Enjoys family time, often attends community activities.



**Emotional:** Shares with youth and other community members about his residential school experience. He seems to be coping well with his past trauma and the loss of his wife. His family is very supportive.

**Spiritual:** Matthew is often out on the land and at his cabin as much as possible. He is active there chopping wood, walking. He goes to church.

## Narrative update

After the visit with Matthew, you approach the office manager to ask why they made the comment they did as Matthew was walking in. The clinic manager reports that Matthew missed an appointment with the nephrologist a few months ago when he was away fishing. You and the clinic manager decide to review how reminder calls are given to ensure patients know the dates of their upcoming appointments. You also recall an education session you attended years ago that mentioned “no shows” might be an indication that Indigenous patients don’t feel culturally safe.

Matthew is doing well and you can see the positive effect that Mathew’s connection to family, culture, and physical activity is having on his health. You suspect his understanding of his renal condition might be limited—when you review his lab work he states “I feel good.” There is a translator who often supports patients in the clinic to understand complex diagnoses. You ask Matthew if he would like the translator to be present at a follow-up meeting to further understand the kidney problem. He agrees. The next appointment goes very well and results in some further adjustments to his medication and a referral to the nephrologist.

You notice that there are a significant number of patients at the clinic who have chronic kidney disease who come to the clinic and need to have a consultation or follow-up with a nephrologist. You organize a meeting to explore having a nephrologist come to the community every three months.

The next time you see Matthew in the clinic, he is doing very well; his BP has improved to 128/90. He shares with you about his residential school experience so you can understand what he and others have lived through.

## Indigenous perspectives – experiences of seeking and receiving care

Matthew: “As a person who survived the residential school experience, where things were done to us without consent or explanation, entering any ‘institutional’ building (like a clinic) causes me to feel anxiety. I have had poor treatment by staff at the local clinic who treat me just the same way as the nuns did back in residential school. They look down on me. I don’t like coming into the clinic, but I know that due to my health conditions, I need to get regular check-ups, and there is nowhere else to go to get care. My wife used to come to my appointments with me. She was able to understand what the doctors are saying better than I can, because I feel such anxiety when I’m at the clinic. Since she has passed, I have a harder time understanding what the doctors are telling me to do.

When this doctor offered translation support from the community member I know, I felt good about that. With his help, I had a different conversation with the doctor and could better understand what he was telling me, translated into my language. I think the doctor might have talked to the staff as well because the next time I came in, I didn't get a dirty look or hear them say unkind things. This doctor is interested in hearing more about my life experiences. I feel like I can offer some stories about my life to him to help his understanding. He is willing to listen, and I am willing to share."

## Learning points

- There is diversity in how Indigenous patients are doing. Not all Indigenous patients, even with intergenerational trauma or adverse childhood experiences, have difficulty managing their health.
- We work to ensure our interactions flatten the power differential between provider and patient
  - Notice and reflect to the patient the beneficial actions that improve health and well-being, strength, courage, and resilience
- Racism—whether subtle, covert, overt, intentional, unintentional, systemic, or individual—is not acceptable. Zero tolerance among colleagues regarding racist comments supports an environment free of discrimination and supports all patients to feel welcome and safe when seeking and receiving care.
- It is important to recognize and advocate for your Indigenous patient when an incident or comment that is inappropriate or unacceptable occurs
- Continuity of care is vital to facilitate engagement in the treatment plan in a culturally safe manner
- A multidisciplinary approach is a critical component of the care family physicians provide. In this case, perhaps an earlier consult with the nephrologist may have reduced progression.
- As family medicine communicators, we share health information and plans with patients and their families
  - Matthew is fortunate that his family is available to support him
- We strive to develop trust, rapport, and ethical therapeutic relationships with patients and their families
  - Listening to an Indigenous patient share sensitive information is vital to supporting them



# Collaborator

## Additional tags:

Advocate, Professional

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## Definition

Family physicians work collaboratively with patients, families, community members, and other health care providers. Family physicians practise cultural humility when building and maintaining inclusive relationships with Indigenous-led organizations (e.g., Indigenous health and social programs, friendship centres, Aboriginal patient navigators), communities, families, and individuals to provide culturally safe, equitable, relationship-based care. Physicians and other health care professionals must appreciate the Indigenous perspectives (history, culture, health status, social issues, etc.) as they work together to help Indigenous peoples.



## Narrative

Tanya, a 28-year-old Haida woman living away from her home community but still connected to her Nation, comes to your office seeking support to do a trial of vaginal birth after cesarean (VBAC) for her fourth pregnancy. You transfer her care to an obstetrician (OB) who offers VBAC.

After one visit with the OB, Tanya felt that she needed more mental and social support and started seeing an Indigenous midwife. The midwife provided long home visits, cultural and social support, which Tanya welcomed and felt were beneficial. Due to transportation issues, Tanya missed two scheduled appointments with the OB.

When Tanya called to book an appointment for her third trimester, she was informed she was discharged from the OB's service as she was deemed a 'no-show' after missing two appointments.

## History

- Depression, otherwise healthy, taking selective serotonin reuptake inhibitors (SSRIs) and prenatal vitamins
- Of her three pregnancies, the first two were vaginal deliveries and the third by cesarean section; unfortunately, the third baby was stillborn by the time of delivery

## Assessment

**Physical:** With multiple factors at play for increased pregnancy complications, close monitoring is important. Patient is taking prenatal vitamins regularly. In good health overall. Walks her children to and from daycare each day.

**Mental:** Doing well with the SSRI medication, though she reports experiencing periods of sadness.

**Social:** Parents live close by. Husband works away a lot, leaving Tanya without car access.

**Emotional:** Still grieving for the loss of her child who was stillborn. Tanya has expressed interest in connecting to cultural supports.

## Narrative update

While waiting for another transfer of care back to the OB, Tanya developed pre-eclampsia close to her due date and required a cesarean section. In a follow-up appointment with you after the baby is born, she expresses frustration about “being bounced around in the system” during her pregnancy and is upset she was unable to deliver vaginally.

## Indigenous perspectives – experiences of seeking and receiving care

- After experiencing a difficult loss with the stillborn delivery of a child before this pregnancy, Tanya has been doing all she can to work on being healthy physically, emotionally, spiritually, and mentally for this pregnancy
- After talking to her family, she sought support for a VBAC from the medical system. It is important for her to try for vaginal birth to support mental and emotional healing from stillborn delivery to avoid retraumatizing.
- She had hoped she could be in the care of her family physician, with whom she has a trusting relationship. She was disappointed to learn her care would have to be transferred to a different physician she didn't know. Due to previous negative experiences with health care professionals and trouble opening to someone new, especially in the context of short specialist appointments, she fears having to re-tell her traumatic birth story to someone she has not developed a trusting relationship with.
- She felt confused as to who she needed to contact regarding missed appointments. She tried calling her family physician to let them know she couldn't make the OB appointment and couldn't get through or leave a message. She didn't have the OB's contact information.

- Her husband was supposed to be back from working away in camp before the second OB appointment, but at the last minute they needed to keep him on longer than expected. When she called her family doctor's office again, staff told her to call the OB and gave her their office number. She was able to leave a message at that time, but didn't hear back about rescheduling.
- There was no communication to let her know that two missed appointments meant she was no longer in the care of the OB

## Learning points

- Our patient has multiple risk factors for adverse outcomes with this pregnancy—closer monitoring, collaboration, advocacy, and communication with other care providers could have better supported our patient and possibly improved outcomes
- Recognize the importance of continuity of care, facilitate necessary transitions in care, and participate in shared care, transfer of care, and/or handover of care involving Indigenous and non-Indigenous health care colleagues and organizations to enable safe, culturally appropriate care
  - In the transfer of care to the OB, stating that the patient might be seeing a traditional midwife at the same time would have been helpful information and could have encouraged OB collaboration with this care provider
  - Increased communication and collaboration could have allowed the patient to not only get the cultural and psychological supports that she needed, but also the safe obstetrical care she required
  - Closer collaboration with the OB's office could have allowed for you to advocate for this patient to not be dropped from her panel because of missed appointments
  - As practitioners, we may need to make extra calls to support patients to navigate the system
  - Reassure your patient that, as her doctor, you will remain involved in her care and stay updated in how her pregnancy and needs proceed, as well as following up with her after delivery
- Communication with the patient that it was important for her to continue seeing the OB even while also seeing the midwife is key to ensure patient understanding
- Understand the impact of social determinants on access to health services from the perspective of Indigenous patients (e.g., geographic location, language, income, employment, status, education, race, etc.) and facilitate appropriate referrals to community programs or organizations
  - Offer information about transportation support for medical care/visits via the local friendship centre to support the patient for making it to her OB appointments
  - Seek out Elders or community doulas who do house calls
  - Connect the patient to an Indigenous patient navigator for further support with health care system navigation and advocacy to help make sure the patient was not lost to follow-up

- Communicate with the OB's office, once you receive the 'no show' note, that the social determinant of transportation can be a challenge for this patient and that she may need support to re-book
- Educate staff and colleagues about the use of pejorative language and attitudes
- This case demonstrates how we, as family medicine practitioners, need to show up in all seven of the CanMEDS roles and to expect that sometimes additional hours are required to practise in a patient-centred way that extends across the life cycle

# Leader

## Additional tags:

Scholar, Professional, Advocate, Expert

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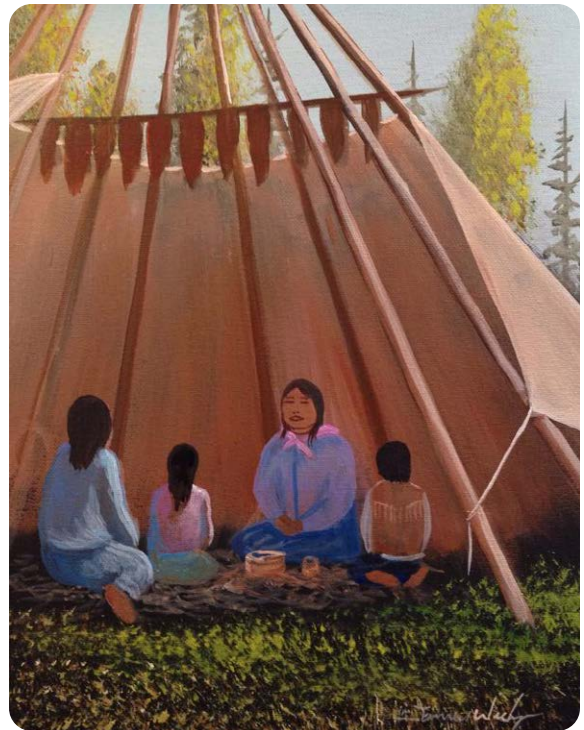
## Definition

As family physicians, we play an important role in improving the health of Indigenous people and advocating for health equity at all levels of the health care system. We do so through strong leadership skills in patient-centred and community-driven approaches. The Leader Role is not restricted to managing people and organizations. As family physicians, we must demonstrate leadership by adhering to high ethical and moral values in our work.

Traditionally, leadership in Indigenous communities demonstrates a different concept of power: leaders put aside their individual needs and represent the voices of the collective. The idea of a ‘helper’ is central to leadership, where the one with the most experience illuminates the path ahead, but the community comes together about what decisions need to be made. In serving Indigenous people, we must resist the temptation toward paternalism and colonial ideology and seek to put the needs of Indigenous patients, families, and communities ahead of our own. As family physician leaders, we can demonstrate humility and challenge concepts of power and hierarchy when serving Indigenous people.

## Narrative

You are a physician providing comprehensive primary care in a rural community with a large population of Indigenous peoples, including an Elders’ Lodge (long-term care (LTC) facility) where you are the main provider. The Indigenous community is seeking sustainable funding to establish a dementia care unit; over the last few years there has been an increase in Elders requiring advanced services. These services include trained staff, close supervision, safety, and support for patients. These Elders have had to be relocated to homes far away from the community and/or are awaiting placement in the nearest hospital. The strains that the COVID-19 pandemic placed on health and social services in the community has highlighted the need for local services. As a respected family physician in the community, the First Nations leaders have invited you to take a lead role in preparing a funding proposal. From your experience working in this community over the years, you have noticed some concerning trends in Elders with dementia and assess this situation from a holistic perspective.





## Assessment

**Physical:** Previously considered a young population with shorter life expectancy. We now see that Elders are living longer and becoming a larger proportion of this population. As a result, rates of dementia are increasing in the Indigenous population.

**Mental:** We know that removal from familiar surroundings can worsen symptoms of dementia. Increased awareness of dementia, its progression, caregiver burnout, and support will help caregivers and family members cope with their loved ones' dementia.

**Social:** Despite excellent home nursing support and a culturally appropriate LTC facility, lack of specialized care for Elders with dementia puts a strain on the entire community due to travel and costs for care far away from the community.

**Emotional:** Sending Elders from their community to distant institutions can be re-traumatizing if they are residential school survivors, spent time in the child welfare system, or if they have spent time in prison.

## Narrative update

While working full days in your clinic and on-call after hours for the Elder's lodge, you barely find time to draft the funding proposal on evenings and weekends. You begin to wonder if you are close to burnout. A colleague in the community sees that you are struggling and recommends that you speak to one of the respected knowledge keepers. You reach out to this Elder, who provides you with guidance for a cultural wellness plan for yourself while also offering suggestions on how you can be successful in completing the funding proposal with a team of community members. When you present this proposal to the community leaders, you invite the Elder to be a co-presenter. The leaders are pleased that you engaged the community in preparing the proposal. You recognize that you are better prepared to cope with the demands of your physician leadership role in the community and that you are never alone. You have also learned that culture is healing.



## Indigenous perspectives – experiences of seeking and receiving care

- Viewing health and the life cycle as holistic is an important practice among Indigenous peoples. Caring for Elders within the community is vitally important, as is having the appropriate care to support health and well-being. There is an understanding that children and Elders are closest to the Creator in their journey. Care that fully supports the highest quality of life and meaningful involvement in the community for Elders is a critical aspect of wellness.
- Cultural supports for Elders are a protective factor. Moving Elders to care homes where cultural practices, familiar surroundings, and language speakers are not present can have a debilitating effect on their well-being and cognitive function.
- When considering the construction or enhancement of care facilities, environments that reflect cultural, language, and Land\* should be factored in

\* Capitalization is intentional in this instance. Connection to the land is a foundational element of Indigenous ways of knowing and being.

- Community engagement and consultation with Elders and other knowledge keepers is important when addressing current and needed health and social services

## Learning points

- Importance of community-centred and team-based approaches; when the community leadership asked you to lead the proposal, they did not mean that you had to do it by yourself
- Self-awareness of your own limitations and how to identify when you need help; holistic perspectives on health can benefit non-Indigenous peoples as well
- Family physician leaders need to attend to their own wellness to achieve success
- Development of partnership with secondary or tertiary health services can be considered; for example, linking with a geriatrician or other specialist could help advance this work in caring for patients with dementia

## Additional information

By 2031 it is expected that the proportion of First Nations Elders over the age of 65 will increase by 3.4 times what it was in 2006.<sup>6</sup>

Although previously considered a rare disease among many First Nations people,<sup>7</sup> British Columbia's Provincial Health Officer's 2007 report on the health and well-being of the province's Indigenous people showed that age-adjusted rates of dementia in status First Nations people (both on- and off-reserve) was on par with rates in the rest of the province, but that onset was at an earlier age.<sup>8</sup>

A more recent study from Alberta shows age-adjusted rates of dementia in status First Nations people living on- or off-reserve in that province are rising. Prevalence rates in 1998 were below those of non-First Nations Albertans, but surpassed the rates by 2009. The Alberta study also showed that First Nations people are being diagnosed at an earlier age and that males are disproportionately affected.<sup>9</sup>

More research is needed into the role of factors such as nutrition, cultures, substances, and addictions in earlier onset of dementia among Indigenous Elders.

# Health Advocate

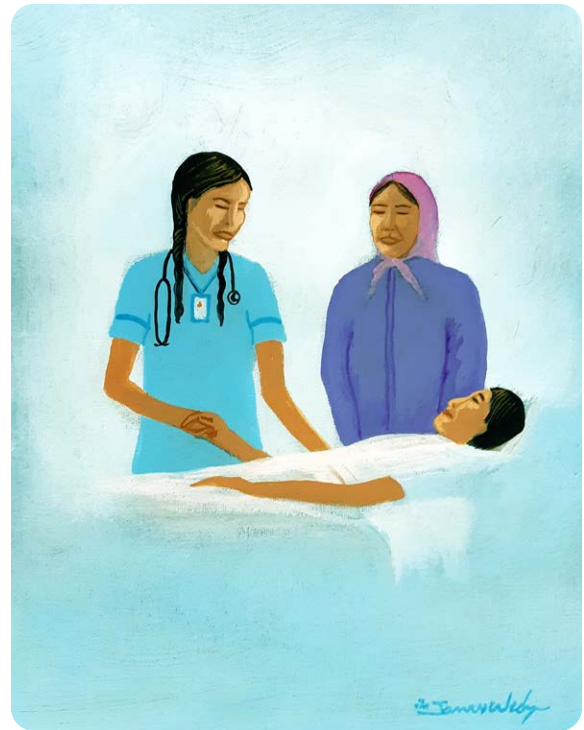
## Additional tags:

Expert, Collaborator, Professional, Communicator

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## Definition

As successful advocates for Indigenous health, family physicians work in partnership with patients, families, and communities. We contribute our expertise and influence to those members of the community to improve health through an understanding of cultural values, strengths, and needs, as well as mobilization of unique, complex, and limited resources. It is important for us as family physicians to learn the policies that govern clinical spaces and the community's unique social, political, and environmental determinants of health. Advocacy must include communication and collaboration with the community's social context and cultural traditions.



## Narrative

Rose is a 28-year-old Dene woman who contracted influenza B. She is fully dependent, bed-bound, and non-verbal due to a progressive neurological condition. She was hospitalized in a small, rural hospital but her condition deteriorated. She progressed to respiratory failure and was intubated. She was medevacked to the regional hospital four-bed intensive care unit, and eventually the health care team and family decided to proceed with palliative care in her community. A few days later she was extubated and unable to maintain her respiratory function. Her sister (and legal guardian) asked for the attending physicians to intubate Rose again and give time to transfer her back to her community and continue comfort care.

## History

Rose's parents had died in their 50s a few years earlier. Her mother's passing at home was traumatic because she looked uncomfortable as she struggled to breathe at the end of her life. The family wanted Rose to have a good death, without pain or anxiety, surrounded by family and friends, and well supported.

The community physician, aware of the experience of Rose's mother's passing, had been visiting their remote fly-in community for two years and had a trusting relationship with the family. The physician had even delivered the sister's daughter several years before. Knowing the community, family, and health infrastructure, the physician advocated for Rose's family's wishes to help her pass on in a good way.

## Assessment

**Physical:** Patient has complex chronic conditions. She is bed-bound, non-verbal, and unable to breathe on her own. Her palliative performance scores as very low, indicating the need for comfort care.

**Mental:** The family experienced a negative palliation experience with the passing of their mother, and felt traumatized and unsupported.

**Social:** Rose is well cared for by her sister. The remote northern community has limited medical supports. Existing nursing staff in the community may be able to assist with palliation at home.

**Emotional/spiritual:** Rose is part of a robust cultural support system that is anticipating her arrival home. Rose's family is also religious and there are two semi-retired nuns in the community who are known to Rose's family.

## Narrative update

Rose's sister asks to bring her home. To do this, they have to transport her safely and comfortably while she is intubated, and then extubate her at home and continue with comfort care.

With no precedent for this kind of care in the community, the physician offers to pull together the necessary team to support the family's wishes. This team includes the health centre, two nurses, and the on-call physician. Medical equipment including a hospital bed and oxygen concentrator are set up in the home.

The physician calls the [BC Palliative Care Physician's Hotline](#), which helps estimate the quantities of the comfort care medications. A pharmacist from the regional hospital agrees to assemble and package these medications and, following the protocol for restricted medications, have them flown into the remote community.

The regional emergency medicine team are assembled to prepare to fly Rose home, and to extubate her upon her arrival at home. Her sister is her non-medical escort for the trip.

Back in the community, the home prepared, local drummers sing outside as Rose is extubated and settled. Rose, who rarely moved, turns toward the drumbeat. There are no issues with sending a second shipment of medication, when required. When Rose experienced distress, the nurses, working with the on-call physician using video technology, were able to settle her. Rose passed peacefully on the sixth day.



## Indigenous perspectives – experiences of seeking and receiving care

- Learn about specific practices and traditions surrounding births and deaths, which are unique to each culture or group (First Nations, Inuit, and Métis)
- When Rose’s mother was dying at home, there were limited palliative care supports. The family had taken on the primary role without respite and were unable to ease her pain and anxiety. This was a very traumatic for the family and they did not want Rose to suffer as their mother did.
- Rose enjoyed involvement in cultural activities; the putting in place ceremony was deeply appreciated.
- Rose’s family remain grateful for the care and support she and they received through her final days
- Afterward, Rose’s sister started a non-profit organization to provide cultural and logistic supports for Indigenous people who are receiving medical care away from home
- The community, through their experience of witnessing Rose’s supported death, improved their trust in the health care system

## Learning points

- Identify collaborative strategies with other health care providers and community supports to optimize resources
- Understand the existing landscape of the Indigenous community’s health care infrastructure and policy. These include communication and community human resources.
- Build trusting relationships with patients; as family physicians involved in longitudinal care, we have this opportunity. In remote northern communities, care is transitional as providers cycle through rotations or locums but do not stay long enough to form relationships. Making an effort to make community connections, even for short stays, can make a big difference to patients we see.
- Enhance outcomes via continuity of care
- Support family wishes. Historically, doctors, government agents, lawyers, businesses, corporations, and researchers have spoken “on behalf” of Indigenous communities and people, leaving the Indigenous voice and experience diminished and not reflected in most platforms.
- Seek out and support strength-based outcomes for the patient and their family
- Try to always think about ways to improve capacity in communities; for example, birth and death doulas, community health nurses and midwives

# Scholar

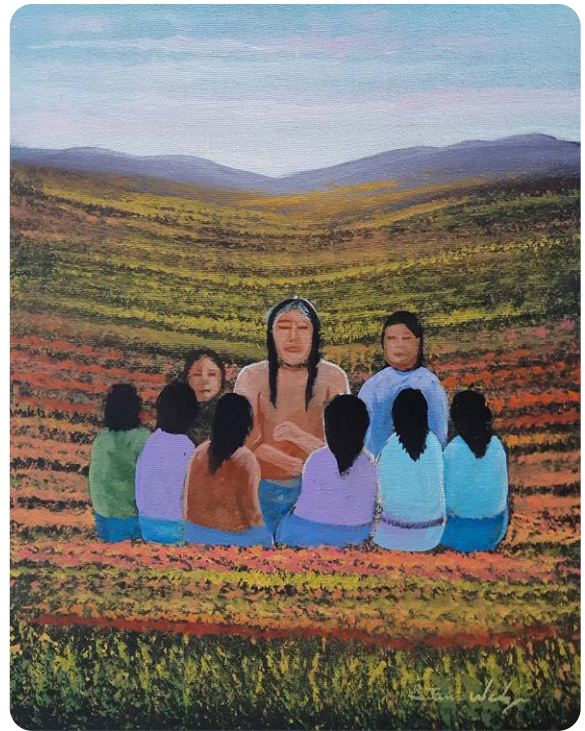
## Additional tags:

Advocate, Collaborator, Communicator, Leader, Expert

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## Definition

As family physicians we must possess a broad range of evidence-based clinical knowledge and practice skills in caring for patients, including emergency medicine. To provide the best care for Indigenous patients, families, and communities, we must pursue further knowledge in epidemiology, health, and social issues relevant to this population, as well as the historical, political, and social contexts of First Nations, Inuit, or Métis populations. While there is a growing body of knowledge in these areas, we must also be aware of non-academic sources of information, such as that of Indigenous leaders, traditional healers, cultural resource persons, or knowledge keepers.



## Narrative

Amber, a 15-year-old girl from a First Nation community in a nearby region, is brought to your clinic by her mother, Bernice, who has been concerned about her. Over the past few months Amber has become withdrawn; she is not spending as much time with friends and frequently skips school. The family moved to Winnipeg in the spring due to flooding in their home community and now live in a downtown Winnipeg hotel. They do not know when or if they will ever be able to move back to their home, which was heavily damaged in the flood. There is speculation that their reserve may be permanently relocated to a new site.

## History

Amber's parents were employed full-time on the reserve but have been unable to find work in the city. Bernice tells you that living in Winnipeg has been difficult for her family. They have been called freeloaders and subjected to threats of violence. Bernice shares that Amber's best friend committed suicide last year.

## Assessment

**Physical:** Physical exam is unremarkable.

**Mental:** Amber shares that she feels depressed and doesn't want to go out due to racial slurs she has experienced in her neighborhood, and she is not coping well with living in the big city.

**Social:** The family has been experiencing financial difficulty since relocating to the city. They depend monthly on the food bank as the parents are not currently employed. Back in their home community, they would enjoy a diet high in traditional foods. Dad is a hunter and fisher but has been unable to get back to the territory to hunt since being relocated to the city.

**Emotional:** Amber shared that she has experienced bullying in her new school.

## Narrative update

In a follow-up appointment, Bernice shares that Amber was participating in a youth program back in their home community and connected to Elders who were helping her deal with the death of her best friend. However, since relocating Amber has not had access to this. She has wanted to get Amber into some counselling, but they cannot currently cover the cost. The bullying at school seems to be escalating and Bernice cannot get her to go to school. Bernice has recently been attending some cultural activities at the Friendship Centre and thinks she may be able to connect to an Elder there who works with youth. She is hoping she can encourage Amber to come with her to the Centre.

## Indigenous perspectives – experiences of seeking and receiving care

- Connection to the land, community, and extended family are integral aspects of health and wellness for this family. Being disconnected from it all has been extremely difficult. This has impacted food security, family connections, cultural traditions, and spiritual practices.
- It can be challenging to navigate different health care systems. At home on the reserve, available wellness supports were known. Living away from home, health care access and support seems fragmented. It is difficult to know where to go and what may or may not be covered under the [Non-Insured Health Benefits \(NIHB\)](#) program.
- Anxiety in reaching out to seek and receive care. Uncertainty and fear are experienced in reaching out to a new care provider. Will we be believed? Will our concerns be dismissed? Will we be prescribed a medication or counselling supports that we cannot afford? Will we experience racism when seeking care?

## Learning points

- Awareness of and familiarity with the NIHB program, which requires some knowledge of treaty rights and supplementary health coverage for Amber to access some mental health supports
  - Research jurisdictional issues (e.g., access to services covered by province, NIHB, or private care)
  - Awareness of [Jordan's Principle](#)
- Recognition of the impacts of relocation on health and social well-being
- Understanding of the impacts of dislocation of land, loss of autonomy
- Awareness of the epidemic of youth suicide among First Nations, Inuit, and Métis youth, including rates, factors, prevention efforts, and impact on communities
- Learn about and use trauma- and violence-informed approaches and healing-centred engagement
- Create an ethical space to positively engage Indigenous patients and a trusting and safe therapeutic relationship
  - Positive reinforcement of engaging in protective factors (i.e., attending cultural teachings at the Friendship Centre or activities for Indigenous youth)
  - Find out from the local Indigenous centre or clinic what resources are available for Indigenous youth and families
- Address racism and discrimination
  - Make sure the patient and her family are seen and heard
  - Use phrasing like “I am sorry you are having to experience this” or “you shouldn’t be treated this way”
  - Affirm that racist words, behaviours, and actions are wrong and harmful
  - Consider reporting to police, if the patient is willing or comfortable
- Knowing about Indigenous community resources and cultural activities
- Being familiar with the system is essential. Seek out additional supports such as Indigenous system navigators to support both you and your patients.

# Professional

## Additional tags:

Advocate, Communicator, Collaborator

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## Definition

The Professional Role calls on us as family physicians to incorporate cultural, social, and ethical dimensions of care with diverse Indigenous patients and populations. Defining competent medical practices with Indigenous patients frames accountabilities to patients, colleagues, the community, and the profession. They direct us to act on cultural, structural, and systemic dynamics that influence health and health care as experienced by Indigenous people. Professional relationships centre on disrupting the exclusion of Indigenous people within society and health care that persists due to the legacy of ongoing colonization. We are urged to be fully aware of and address the oppression, power imbalance, and racism that is often re-enacted within health care. When working with others we seek to sustain non-competitive collaborative approaches, valuing interdependence, and flattening hierarchy to counter oppression and power imbalance. We facilitate effective and collaborative team-based care.



## Narrative

A 73-year-old Haudenosaunee woman, Agnes, works as a language instructor in her community. She presents to the local clinic with abdominal pain and is diagnosed with primary biliary cirrhosis and liver lesions. Throughout her experience at the local health care centre, from intake at the clinic through to diagnoses by her physician, she is asked repeatedly about her alcohol intake by many health professionals. Agnes leads a very traditional lifestyle. She does not drink or use tobacco and eats a wide variety of traditional foods.

Ashamed of her diagnosis, Agnes does not tell anyone about her health crisis. She is worried that people will think she is a closet alcoholic.

## Assessment

**Physical:** Blood tests reveal excess of bilirubin and enzymes that indicate extensive liver damage. Agnes reports swelling in her legs, feet, and abdomen and that she is experiencing nausea.

**Mental:** Agnes reports having difficulty concentrating recently and feeling confused often.



**Social:** Agnes is well-connected in her community and is a known water protector/activist. Many industries are present in and around her community that pollute the air, water, and soil with heavy metals.

**Emotional:** Agnes is very emotional upon hearing her diagnosis. She is angry with the physician and in a state of disbelief as she yells, “I don’t even drink alcohol! This can’t be happening!” Agnes seems to slur her speech and is rude to staff on her way out of the clinic.

## Narrative update

Agnes, so embarrassed by her diagnosis and its perceived association with alcohol use, decides to not return for additional care. She did not accept an offer of home care because ‘everyone would think ...’

She is brought into the emergency department less than a week later by a close friend, in obvious medical distress. There is nothing more to be done. Palliative and comfort care is initiated, and she dies only 12 hours later in hospital. Her family is now asking questions about her diagnosis and why more was not done to support her.

## Indigenous perspectives – experiences of seeking and receiving care

Agnes: “I have lived my life in a way that honours my ancestors. I am a land defender and water protector. I am a grandmother who speaks her mind. I live in a good way and share teachings and language in my community with the younger people. I do not drink alcohol and eat traditional food as often as I can.

The stereotyping and racism I have felt in the health system impacts my care. I know members of my community will not go to the health centre, as they are afraid of the treatment they will receive there. I know that some people think all Indigenous people are alcoholics. Hearing that I have a liver disease doesn’t seem right to me. I live a good life and I don’t drink. If I accept their diagnosis and home care, people will talk.”

## Learning points

- As family physicians, we recognize and address racism, oppression, and imbalance of power within clinical approaches and relationships
- We maintain an inclusive approach that respects, elicits, and explores Indigenous perspectives
  - Had Agnes felt acknowledged that she was not a ‘closet alcoholic’, she may have accepted her illness, help, and had a more comfortable death

- We recognize implicit bias displayed by health professionals regarding patient’s perceived alcohol use (stereotyping) and diagnosis
  - Agnes grew up in a traditional home, eating a lot of fish. The river where her community fishes is downstream of many industries that pollute the water, air, and soil with heavy metals.
  - There are high anecdotal rates of autoimmune and neoplastic disease in Indigenous communities across Canada
  - Mercury causes neurological effects on the dorsal columns of the spinal cord and cerebellum, which clinically make the patient appear intoxicated
  - Primary biliary cirrhosis is thought to be an HLA gene related illness and is found in Indigenous peoples; there is very little research
  - NASH cirrhosis is also common, for which there are strong environmental factors
  - Asking a patient **repeatedly** about their alcohol use does little to help the patient and can cause harm
- When asking about alcohol use, always do so in a good way; ask with compassion and explain why we ask
- Agnes’ tragic situation points to the need for making continuity of care a priority in all our practices, even if we are locums or short-term residents. Choosing to live in the communities where we work and embracing life in that community decreases the likelihood that these situations will arise.
- If we lived there, we would likely know that Agnes is a leader who lives a sober life. We would see each other as whole persons who are able to collaborate as equals in the work of sorting out her health issues and what can be done to help her, in a way that fosters trust.
- We suggest that learners, indeed all of us physicians, read ‘around our patient’s case.’ For example, we need to learn what causes cerebellar dysfunction other than alcohol, what the research says about environmental and genetic factors in this patient’s condition, and remember to keep an open mind regarding the differential diagnoses and the possible etiologies.
- When our patients do not come for follow-up appointments or adhere to the treatment advice provided, it is imperative to seek to understand what their stories are and what factors are making their engagement with us challenging. So often there are reasons people don’t show up for appointments or don’t fill their prescriptions. We need to manifest compassion, flexibility, and openness to hear what their experiences are.

# Appendix A

CanMEDS Roles	CanMEDS Key and Enabling Competencies (CFPC Indigenous Health Committee)	Indigenous Health Values (Royal College Indigenous Health Committee)	Indigenous Health Principles (Royal College Indigenous Health Committee)
<b>Medical Expert</b>	<ul style="list-style-type: none"> <li>• We practise high-quality generalist medicine within the scope of professional activity and embedded in the context of the Indigenous people we serve</li> <li>• A patient-centred practice for Indigenous patients may involve, according to their wishes, their family, community, and/or Nation</li> <li>• Clinical plans are developed in collaboration with Indigenous patients. As family physicians, we recognize and flatten the power discrepancy between practitioner and patient. We consider the patient's wishes as informed by their Indigenous context. We present advice in a culturally safe manner. As family physicians, we commit to transparency and communicating thought processes that have led to conclusions, differentials, and recommended treatments.</li> </ul>	<ul style="list-style-type: none"> <li>• Cultural Safety</li> <li>• Consensus</li> </ul>	<ul style="list-style-type: none"> <li>• As a culturally safe physician, we are complete health care practitioners who embrace Indigenous knowledge/science, understand and accept that racism exists, and how historical and/or intergenerational trauma affects the health and well-being of the Indigenous patient. We take steps to foster anti-racism interventions.</li> </ul>
<b>Communicator</b>	<ul style="list-style-type: none"> <li>• We work to ensure interactions do not perpetuate inequity</li> <li>• We develop rapport, trust, and ethical therapeutic relationships with patients and their families</li> <li>• We listen to, elicit from, and synthesize accurate and relevant information from, and perspectives of, patients and their families</li> <li>• We share health information and plans with patients and their families</li> </ul>	<ul style="list-style-type: none"> <li>• Transparency</li> <li>• Respect</li> <li>• Accountability</li> </ul>	<ul style="list-style-type: none"> <li>• As culturally safe physicians, we communicate in a clear, honest, and respectful dialogue about health matters, and see a mutual responsibility between ourselves and the Indigenous patient/community for achieving shared health outcomes.</li> </ul>
<b>Collaborator</b>	<ul style="list-style-type: none"> <li>• We respect inclusiveness by demonstrating skills in fostering and maintaining collaborative and ethical relationships with Indigenous individuals, organizations, and communities</li> <li>• We cultivate and maintain culturally safe health care environments by embodying the principles of Indigenous anti-racism in clinical, educational, research, and administrative roles</li> <li>• We recognize the importance of continuity of care, facilitate necessary transitions in care, and participate in shared care, transfer of care, and/or handover of care involving Indigenous and non-Indigenous health care colleagues and organizations to enable safe, culturally appropriate care</li> <li>• We work to understand barriers faced by Indigenous patients accessing health services and supplies, including social determinants of health and jurisdictional factors that inhibit health care access, and act to coordinate referrals that align with Indigenous patients' needs</li> </ul>	<ul style="list-style-type: none"> <li>• Partnership</li> <li>• Access</li> <li>• Trust</li> <li>• Autonomy</li> </ul>	<ul style="list-style-type: none"> <li>• As a culturally safe physician, we recognize that the Indigenous patient-physician relationship is sacrosanct and without hierarchy or dominance, this partnership fosters access to health care and the resources necessary for health and wellness of the person, family, and community. It also facilitates our ability to work effectively with community institutions to help the patient.</li> </ul>

CanMEDS Roles	CanMEDS Key and Enabling Competencies (CFPC Indigenous Health Committee)	Indigenous Health Values (Royal College Indigenous Health Committee)	Indigenous Health Principles (Royal College Indigenous Health Committee)
<b>Leader</b>	<ul style="list-style-type: none"> <li>• As helpers, family physicians embody a humble leadership style that respects Indigenous world views and perspectives as equal to Western ways in efforts to reduce health inequities experienced by Indigenous people</li> <li>• As family physician leaders we continually engage in the practice of self-improvement</li> <li>• As family physician leaders, we challenge systemic racism and encourage others to do so</li> <li>• Family physician leaders can go beyond their practices to reduce health inequities experienced by Indigenous people</li> </ul>	<ul style="list-style-type: none"> <li>• Self-determination</li> <li>• Economy</li> <li>• Sustainability</li> <li>• Equity</li> </ul>	<ul style="list-style-type: none"> <li>• As a culturally safe physician, we equip ourselves with the tools, knowledge, education, and experience to achieve the highest form of evidence-informed professional competencies, while practising with cultural humility, fostering an environment of cultural safety, and proactively pursuing anti-racism interventions.</li> </ul>
<b>Health Advocate</b>	<ul style="list-style-type: none"> <li>• As advocates, we are aware of the Report of the Royal Commission on Aboriginal Peoples, the Truth and Reconciliation Commission and its Calls to Action, and the Inquiry into Murdered and Missing Indigenous Women and Girls and its Calls to Justice, which are key foundational documents</li> <li>• We understand the difference between Indigenous and dominant Western paradigms</li> <li>• We work to understand the existing landscape of the Indigenous community's health care infrastructure and policy</li> <li>• We contribute to the continuing development of an Indigenous public health policy</li> </ul>	<ul style="list-style-type: none"> <li>• Holism</li> <li>• Recognition</li> </ul>	<ul style="list-style-type: none"> <li>• As a culturally safe physician, we embrace Indigenous identity as the platform that promotes holistic health and encourages active participation of Indigenous people, in concert with physicians and other health care professionals, as "agents of change for health."</li> </ul>
<b>Scholar</b>	<ul style="list-style-type: none"> <li>• We appreciate cultural humility and in doing so, recognize that knowledge of Indigenous health, broadly defined, is needed to advance competence and capacity and to provide culturally safe care to Indigenous patients, families, and communities</li> <li>• We actively pursue and accrue continuing education in Indigenous health through learning and experiential activities</li> <li>• We guide peers, medical students, residents, and health care team members in their learning about Indigenous health and social issues, including doing so together as needed, to eventually attain culturally safe care. Learning and teaching others (humility) are key Indigenous values and ethics that help everyone do this.</li> <li>• We participate in patient education or teaching that is amendable to the culture, language, community context, and capacity of the Indigenous patient and their family member(s)</li> <li>• We contribute to generating health and other knowledge that will enable capacity of the health care team and Indigenous community to achieve improved health</li> </ul>	<ul style="list-style-type: none"> <li>• Continuity</li> <li>• Openness</li> <li>• Distinctiveness</li> <li>• Evidence</li> <li>• Shared Research</li> </ul>	<ul style="list-style-type: none"> <li>• As a culturally safe physician, we understand that Indigenous health is an integral component of medical research, education, training, and practice, and that this research is based on evidence from empirical sources, critical appraisal of relevant material beneficial to patients, leading Indigenous and non-Indigenous practices, and lifelong learning that can be adapted to serve Indigenous patients. Reflective practice grows our skills in the collaborative patient-physician relationship.</li> </ul>

CanMEDS Roles	CanMEDS Key and Enabling Competencies (CFPC Indigenous Health Committee)	Indigenous Health Values (Royal College Indigenous Health Committee)	Indigenous Health Principles (Royal College Indigenous Health Committee)
<b>Professional</b>	<ul style="list-style-type: none"> <li>We work to demonstrate a commitment to clinical excellence, focusing on not perpetuating colonization</li> <li>We demonstrate a commitment to Indigenous ethical concepts within clinical approaches</li> <li>We demonstrate a commitment to reflective practice</li> </ul>	<ul style="list-style-type: none"> <li>Self-reflection</li> <li>Transferability</li> <li>Self-regulation</li> </ul>	<ul style="list-style-type: none"> <li>As culturally safe physicians, we are committed to the well-being of Indigenous patients, their families, communities, and cultures through ethical behaviours, compassions, integrity, respect, and a commitment to clinical competencies that engender health of Indigenous people.</li> </ul>

## Endnotes

- Charon R. The patient-physician relationship. Narrative medicine: a model for empathy, reflection, profession, and trust. *JAMA*. 2001;286(15):1897-1902.
- Kitty D, Funnell S, eds. *CanMEDS-FM Indigenous Health Supplement*. Mississauga, ON: The College of Family Physicians of Canada; 2020. Accessed April 14, 2023. <https://www.cfpc.ca/CFPC/media/PDF/CanMEDS-IndigenousHS-ENG-web.pdf>
- Department of Economic and Social Affairs Social Inclusion. *United Nations Declaration on the Rights of Indigenous Peoples*. New York, NY: United Nations; 2008. Accessed April 14, 2023. [https://www.un.org/esa/socdev/unpfii/documents/DRIPS\\_en.pdf](https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf)
- Royal College of Physicians and Surgeons of Canada. *Royal College Indigenous health values and principles statement*. Ottawa, ON: Royal College of Physicians and Surgeons of Canada; 2013. Accessed April 14, 2023. <https://www.royalcollege.ca/rcsite/health-policy/indigenous-health-e>
- College of Family Physicians of Canada, Advancing Rural Family Medicine: The Canadian Collaborative Taskforce, Society of Rural Physicians of Canada. *Advancing Rural Family Medicine: The Canadian Collaborative Taskforce Backgrounder*. Mississauga, ON: College of Family Physicians of Canada; 2017. Accessed February 15, 2023. [https://www.cfpc.ca/CFPC/media/Resources/Education/ARFM-2016-Backgrounder\\_ENG-Rev-Feb-2017.pdf](https://www.cfpc.ca/CFPC/media/Resources/Education/ARFM-2016-Backgrounder_ENG-Rev-Feb-2017.pdf)
- Statistics Canada. Population Projections by Aboriginal Identity in Canada, 2006 to 2031. Accessed February 15, 2023. <https://www150.statcan.gc.ca/n1/pub/91-552-x/91-552-x2011001-eng.htm>
- Hendrie HC, Hall KS, Pillay N, Rodgers D, Prince C, Norton J, et al. Alzheimer's disease is rare in Cree. *Int Psychogeriatr*. 1993;5(1):5-14.
- Provincial Health Officer. *Pathways to Health and Healing – 2nd Report on the Health and Well-being of Aboriginal People in British Columbia*. Victoria, BC: Ministry of Healthy Living and Sport; 2009. Accessed February 15, 2023. <https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/office-of-indigenous-health/abohlth11-var7.pdf>
- Jacklin KM, Walker JD, Shawande M. The emergence of dementia as a health concern among First Nations populations in Alberta, Canada. *Can J Public Health*. 2012;104(1):e39-e44.